



223E (12/4/84)
Revised (6/98)

STATE OF UTAH
LABOR COMMISSION OF UTAH
DIVISION OF INDUSTRIAL ACCIDENTS

RENEWAL APPLICATION FOR SELF-INSURANCE

PLEASE REVIEW THE RENEWAL APPLICATION, AS IT MUST BE COMPLETED IN FULL AND ALL REQUIRED ENCLOSURES MUST BE INCLUDED, OR IT MAY BE RETURNED WITH A **\$150.00** RE-APPLICATION FEE

Self-Insured Name: _____

1. **Address of principal office** _____

E-Mail Address: _____ Internet Location: _____

2. **Person responsible for self-ins. program:** Name _____ Title _____

Mailing Address: _____

Phone # _____ Fax # _____ E-Mail Address: _____

3. **Contact if other than the above name:** Name _____ Title _____

Mailing Address: _____

Phone # _____ Fax # _____ E-Mail Address: _____

4. **Utah contact different from above names:** Name _____ Title: _____

Utah Mailing Address: _____

Phone #: _____ Fax #: _____ E-Mail Address: _____

5. **Person in charge of Safety Program:** Name _____ Title: _____

Mailing Address: _____

Phone #: _____ Fax #: _____ E-Mail Address: _____

6. **Send correspondence to:** Name _____ Title: _____

Mailing Address: _____

Phone #: _____ Fax #: _____ E-Mail Address: _____

7. **All open Utah workers' compensation claims, regardless of injury year.**

a. Outstanding workers' compensation claims as of: _____ (date)

b. Number of outstanding claims: _____

c. Medical Reserve to be paid in the future: \$ _____

d. Indemnity Reserve to be paid in the future: \$ _____

e. Total Amount of Reserves: \$ _____

f. Previously Reported Amount: \$ _____

g. Total adjustment: \$ _____

h. Where do you account for your Reserves:

General Fund Account: _____ Liability Fund Account: _____ Other: _____ -please attach explanation

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8. a. **Information regarding the number of claims, amounts paid, burial benefits and dependent's benefits for the last three calendar years.**
b. **Losses are to be reported for the calendar year incurred regardless of when payment was made.**

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FATALITIES:

# of Accidents			
Medical Expenses	\$ _____	\$ _____	\$ _____
Burial Benefits	\$ _____	\$ _____	\$ _____
Dependents' Benefits	\$ _____	\$ _____	\$ _____
Total	\$ _____	\$ _____	\$ _____
* Reserves	\$ _____	\$ _____	\$ _____
Total Incurred Liability	\$ _____	\$ _____	\$ _____
Previously Reported	\$ _____	\$ _____	\$ _____
Total Adjustment	\$ _____	\$ _____	\$ _____

NONFATALS:

# of Accidents			
Medical Expenses	\$ _____	\$ _____	\$ _____
Temporary Total	\$ _____	\$ _____	\$ _____
Temporary Partial	\$ _____	\$ _____	\$ _____
Permanent Partial	\$ _____	\$ _____	\$ _____
Permanent Total	\$ _____	\$ _____	\$ _____
Total amount paid	\$ _____	\$ _____	\$ _____
* Reserves	\$ _____	\$ _____	\$ _____
Total Incurred Liability	\$ _____	\$ _____	\$ _____
(total amount paid on the calendar year's claims + the estimated reserves set aside to be paid on the outstanding claims for the same year)			
Total Incurred Liability-			
Previously Reported	\$ _____	\$ _____	
Total Adjustment	\$ _____	\$ _____	

* Future estimated amount to be paid on claims incurred during the calendar year that the injury/illness occurred. For instance, you may have previously reported a \$500,000 reserve for the injuries occurring during the calendar year of 2001. This year you now have set reserves at \$400,000 for the 2001 losses. The adjusted amount would be \$100,000.

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9. Claims handling Service (TPA):

Name: _____ Contact Person: _____
Address: _____ Toll Free Phone #: _____
E-Mail Address: _____ Internet Location: _____

If the TPA and/or claims adjuster is not located in Utah, who is their **Designated Agent**? _____
_____ Phone #: _____

10. Have there been any changes within the past year pertaining to the following areas? If so please provide information related to any statement with a yes response.

- a. Loss prevention Service Y ____ N ____
- c. On site physician Y ____ N ____
- d. Major changes to your employee handbook or procedures concerning workers' compensation Y ____ N ____
- e. Managed health care provider, or designated health care provider Pertaining to workers' compensation Y ____ N ____
- f. Number of Employees _____
- g. Gross payroll exceeding 5 percent from previous year Y ____ N ____
- h. Has the company formed, acquired, changed, divested of, merged or started new business operations on their subsidiaries, companies or divisions since the last application, or from the original application ? Y ____ N ____

If yes, please attach an explanation along with the following information:

Name, Address, UI#, FEIN#, Effective date, Number of employees, Classification.

11. The Company's NCCI Experience Modification as reported to the Utah Tax Commission for the previous calendar year: _____.

12. Has the company received any OSHA citations within the last year Y ____ N ____ for the state of Utah? If so, how many _____? Attach an explanation of each citation.

13. The renewal application must include:

- a. Audited Financial Statement (if the financial information cannot be obtained from Dun & Bradstreet)
- b. \$650.00 renewal fee
- c. Excess workers' compensation insurance certificate- if changed since previous year. Attach a copy of the insolvency endorsement also. **The excess carrier is still liable, if we do not receive a cancellation notice, even though they have an expiration date on the policy.**

14. **The entire contents of this renewal application, including enclosures, are certified to be correct to the best of my knowledge, information and belief.**

Name of Corporation or Public Entity

Signature of Official of Corporation or Public Entity
with binding authority

15. **The entire contents of this renewal application, including enclosures are certified to be correct to the best of my knowledge, information and belief.**

By: _____
Signature

Printed or typed name of person filing this form

Address: _____

Phone # _____ Fax # _____

Witnessed this _____ day of _____, 20____

By _____